State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 1 (Month) 29 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 2/1/18

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med ab procedure initiated per FDA regimen on 1/29/18. Pt. c/o no results from medication - was given 2nd dose of misoprostol on 2/1/18. Pelvic ultrasound on 2/6/18 showed failed procedure. Surgical aspiration was done on 2/6/18; pt did well post-op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy S Kress MD/DO

Date 3/16/18

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
2018

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